

PORTER (M.F.)

SOME MOOT POINTS IN THE TREATMENT OF  
APPENDICITIS.

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APPENDICITIS.<sup>1</sup>**

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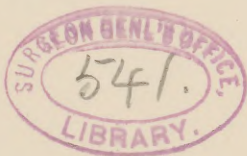
I DESIRE to premise this paper by saying that it is based very largely on the literature of the subject. My own experience has not been sufficient to allow me to give any great weight to deductions drawn from it alone.

Briefly stated, I have had under my care within the past seven years fifteen cases of appendicitis. Eight were pus-cases, seven of which were treated by incision and drainage and one by removal of the appendix. One case was drained through the healthy peritoneal cavity. In the other six cases the peritoneal cavity was not opened.

Seven cases were treated without operation. All recovered. There has been no relapse and no permanent fistula. Two of the cases are too recent to determine as to the permanency of the cures.

While I believe appendicitis to be from start to finish a surgical disease—*i. e.*, one demanding the services of a surgeon—I cannot subscribe to the doctrine that all cases require operation. My experience, together with a careful study of the subject,

<sup>1</sup> Read at the meeting of the Madison County Medical Society, Alexandria, Ind., July 2, 1895.



compels me to believe that by the exercise of good surgical judgment a large number of cases will be found in which non-operative treatment will yield the best results. In a previous paper<sup>1</sup> seventy-seven cases were tabulated in which operation was not deemed advisable; all recovered without recurrence so far as known, though all of them could not be followed. To these I can now add two more occurring in my own practice. Richardson, of Boston, also reports<sup>2</sup> fifty cases treated medically, without a death.

When there is pus, perforation, or severe peritonitis, operation is demanded; as it is also in those cases in which there is imminent danger of those conditions arising. Of course, I am aware that many hold that no man can tell when a mild case will develop into a severe one, which an operation cannot save. I believe this to be possible, but contend that it is a rare exception. In this connection we must not reckon without those fulminant cases in which fatal conditions obtain in a few hours, and in which death results, no matter how prompt the operative interference. In these cases fatal sepsis, peritonitis, or other fatal conditions are present when the symptoms first manifest themselves. In my paper already referred to are tabulated fourteen primary cases in which there was suppuration or perforation almost from the beginning.

Chronic cases, and cases in which recurrences are frequent, should, in my judgment, be subjected to operation, for the risk of operation in those cases is

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<sup>1</sup> American Journal of the Medical Sciences, December, 1893.

<sup>2</sup> American Journal of the Medical Sciences, January, 1895.

no greater than one would be willing to take for the chance he would have of permanent and complete recovery.

Before this question can be definitely settled, it seems to me necessary to collect a large number of cases from the practice of those who operate in all cases as soon as the diagnosis can be made and wherein they have had the opportunity of making early diagnoses, and an equally large number of cases treated under similar conditions by those who take the position that some cases require operation and others do not. As yet the statistics for such comparison are not adequate.

In case of operation there can be no question that the appendix should be removed in cases without pus, cases of endo-appendiceal abscess, and in the majority of peri-appendiceal abscesses in which it is necessary to carry the drainage through the general peritoneal cavity; also in cases of gangrene or perforation without limiting adhesions.

Exception should be made in favor of rapid opening, cleansing, and drainage, preferably with gauze, in cases of this latter class operated upon *in extremis*. In this class of cases prolonged operation means death, and the surgeon should sacrifice the ideal for the sake of the life in his hands, albeit he may but rarely succeed in saving it.

Concerning those cases in which there is a circumscribed collection of pus that can be opened without entering the general cavity of the peritoneum there is much difference of opinion. Maurice Richardson says:<sup>1</sup> "If, for no other reason, the low

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<sup>1</sup> Loc. cit.



mortality in cases of circumscribed abscess, and the perfectly satisfactory and permanent results that have followed simple incision and drainage, are sufficient grounds for limiting our operations to the cavity itself." He has had but two recurrences after drainage, and in one of these the drainage was through the rectum. That appendisectomy is attended with infinitely greater primary danger than simple drainage in these cases cannot, of course, be denied. One need only to read the reported cases to be convinced that, already, lives that might have been saved by simple incision and drainage have been sacrificed through adherence to the dogma that the appendix should always be removed. To offset this greater danger there should be unquestionable proof that the removal of the appendix offers security against recurrence or other dangers that, though perhaps not so immediate, are still none the less real. The cases thus far reported fail to furnish this proof.

Cases of recurrence of abscess are not unknown by any means after the so-called "ideal" operation. In a case reported by Richardson,<sup>1</sup> operated upon by Dr. Beach, who removed the appendix, the patient subsequently developed an abscess, which was opened and drained, and a week later was seized with sudden and violent abdominal pains, and died.

Dr. Fowler,<sup>2</sup> of New York, also reports a case in which an abscess developed three months after an appendisectomy.

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<sup>1</sup> Boston Medical and Surgical Journal, August 4, 1892.

<sup>2</sup> Annals of Surgery, May, 1895.

Dr. Richardson<sup>1</sup> reports recurrence of all symptoms of appendicitis a year after a removal effected by him, but in which the symptoms subsided without further operative interference. A. C. Bernays, in a letter to me, reports a case in which after removal of the appendix there were two relapses, death following the operation in the second relapse. Other cases of similar kind might be cited, but the foregoing are sufficient to show that appendisectomy does not render patients upon whom it is performed absolutely immune from further trouble in the right iliac region.

Theoretically there would be, it seems at first sight, great advantage in removing the appendix, inasmuch as the ligature shuts off communication between the abscess-cavity and the bowel; while in removing the appendix we remove the origin of the trouble. Practically, however, in a great many cases this communication between the bowel and the abscess has already been closed by inflammatory processes; while the appendix itself is only one among many equally potent sources of infection. The abscess-walls are infiltrated with germs and the coats of the bowel are softened, and through them infection is constantly being added. Removal of the appendix does not remove these sources of infection, while the tearing of the adhesions and the manipulations necessary to removal of the appendix liberate these germs from the abscess-walls, inhibit the power of resistance of the tissues, and increase the transmigration of the germs from the bowel. In my paper already referred to I say: "The complete and

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<sup>1</sup> Loc. cit.

permanent recovery of the patient after removal of the appendix in no small measure depends upon the treatment of the stump. The ideal method seems to be that in which the stump, after ligation, is turned into the cecum and buried by Lembert sutures as described by Senn,<sup>1</sup> and described and illustrated by Morris in the *New England Medical Monthly*, April, 1893, p. 331. Indeed, I am convinced by a careful study of all the literature upon this point accessible to me that, unless the stump be thus treated or in some way be covered by peritoneum after ligation, the removal of the appendix leaves the patient in great danger of perforation." I am still of the opinion that this ground is well taken. This treatment of the stump is not practicable in the class of cases under discussion; hence, in them fecal fistulæ are but little if any more uncommon after appendisectomy than after incision and drainage.<sup>2</sup>

By removing the appendix we unquestionably remove one source of infection, and therefore it should be removed if it can be done without additional risk. However, in the majority of cases of the class now under discussion the advantages over incision and drainage that removal of the appendix offers are more than counterbalanced by the risks that it adds.

Another objection to too close adherence to the "ideal" operation is that it must inevitably lead to unnecessary operations. Not every collection of

<sup>1</sup> Journal of the American Medical Association, Nov. 2, 1889.

<sup>2</sup> The only fecal fistula that I have had in my own practice was after an appendisectomy in a pus-case. It closed, however, in a short time.



pus in the right iliac region, even in males, has its origin in the appendix. I saw a case at Defiance, Ohio, in consultation with Dr. Thatcher, in which a diagnosis of appendicitis with abscess had been made. I concurred in the diagnosis, but the man refused operation. He died in a few days, and an autopsy showed the appendix healthy, the pus being due to ulceration of the cecum. Rushmore<sup>1</sup> reports a similar case. Murphy<sup>2</sup> reports a case of total destruction of the mucous membrane of the colon, with a large abscess.

I think we are warranted in concluding as follows :

1. All cases of appendicitis do not require operation ; on the contrary, some cases are best treated without operation.

2. In cases requiring operation the appendix should be removed : (*a*) when there is no pus ; (*b*) when an endo-appendiceal abscess is present ; (*c*) as a rule, when there is a peri-appendiceal abscess that requires drainage through the general peritoneal cavity ; and (*d*) when there is general peritonitis without adhesions, with the exception noted.

3. A simple incision should be made and drainage provided in cases with circumscribed abscess, when this can be done without opening the healthy peritoneal cavity. An exception should be made to this rule in cases in which the removal of the appendix will not add to the gravity of the operation.

47 WEST WAYNE STREET.

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<sup>1</sup> Annals of Surgery, vol. xix, pp. 577, 578.

<sup>2</sup> Journal of the American Medical Association, March 3 to 24, 1894. Case 125.





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